

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4567

CERTIFICATE OF DEATH

04513

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>				c. LENGTH OF STAY IN 1b <u>18 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reeder Nursing Home</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown 10 x 2.2</u>			
3. NAME OF DECEASED (Type or print) First <u>E.</u> Middle <u>Walter</u> Last <u>Beachley</u>				4. DATE OF DEATH Month <u>4</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/10/1871</u>	9. AGE (In years last birthday) yrs. <u>85</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>store owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>grocery store</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ezra Beachley</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Sanner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Floyd Main, Middletown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage (Hemiparesis)</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension - Arteriosclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH. <u>10 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>Nov</u> , 1956, to <u>April 19</u> , 1957, that I last saw the deceased alive on <u>April 18</u> , 1957, and that death occurred at <u>5:10 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Elmer Harp</u> M.D.				ADDRESS (Street, City or Town, State) <u>Middletown</u> DATE SIGNED <u>4-19-57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. J. Elmer Harp</u>				<u>Middletown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/21/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Apr. 20, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Best</u>	

CERTIFICATE OF DEATH

BUREAU V. E.

APR 23 1957

RECEIVED

4514

CERTIFICATE OF DEATH

04514

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 52 Harmons Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grace Middle May Last Benedict		4. DATE OF DEATH Month 4 Day 3 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1890
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Kelmer		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Harvey S. Benedict Jr.		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/2/57 , 19 57 , to 4/3/57 , 19 57 , that I last saw the deceased alive on 4/3/57 , 19 57 , and that death occurred at 11 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED William F. Young M.D. William F. Young 4/5/57			
ACTUAL SIGNATURE William F. Young			
PHYSICIAN'S NAME (Type) William F. Young			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-6-57	
22c. NAME OF CEMETERY OR CREMATORY XXXX Rose Hill		22d. LOCATION (City, town, or county) (State) Mt. Alto Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		24a. REC'D BY REGISTRAR Apr. 8, 1957	
24b. REGISTRAR'S SIGNATURE Wm. F. Young			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Place of Birth		Date of Birth		Date of Death	
Cause of Death		Manner of Death		Occupation	
Residence		Hospital		Physician	
Burial Place		Burial Date		Burial Time	
Signature of Registrar		Signature of Physician		Signature of Coroner	
Date of Registration		Date of Death		Date of Burial	

RECEIVED
APR 10 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 215 5-2-57 et

Items 18-20 Film 215 5-14-57 as

CERTIFICATE OF DEATH

Reg. Dist. No.

04515

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Boonsboro Md. Hagerstown			
f. STREET ADDRESS 218 N. Patomac Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle Letha Last Bomberger				4. DATE OF DEATH Month April Day 24 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3 1869		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 6 Days 20	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Williamsport Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emmanuel Bomberger				14. MOTHER'S MAIDEN NAME Martha Byers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Louis Bomberger David West Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) II Fractured hip - DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 8 yrs. 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 902.7						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was confused and got out of bed without assistance					
20c. TIME OF INJURY Hour a. 11 Month April Day 23 Year 57	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Fahney-Keedy Home Boonsboro		20f. (City or town) Wash.		(County) (State) Md.	
21. I certify that I attended the deceased from April 20 , 19 57 , to April 24 , 19 57 , that I last saw the deceased alive on April 23 , 19 57 , and that death occurred at 7:26 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. W. He Van		M.D. Boonsboro		ADDRESS (Street, city or town, state) Boonsboro		DATE SIGNED 4/24/57	
PHYSICIAN'S NAME (Type) G. W. He Van		22. BURIAL, CREMATION, REMOVAL (Specify) Burial					
22b. DATE THEREOF April 26-57		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		22d. LOCATION (City, town, or county) Williamsport Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. Leaf Williamsport, Md.				24a. REG'D BY REGISTRAR Apr. 26 1957		24b. REGISTRAR'S SIGNATURE Chas. H. Bowers	

CERTIFICATE OF DEATH

BUREAU V. S.

APR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04516

Reg. Dist. No. 302

4516

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.			c. LENGTH OF STAY IN 1b 10 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland 03		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 51 Harken Alley				d. STREET ADDRESS 51 Harken Alley		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Betty Middle Jane Last Breadus				4. DATE OF DEATH Month 4 Day 17 Year 19 57			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 29 1933	
9. AGE (In years last birthday) 23 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Private family		11. BIRTHPLACE (State or foreign country) Harrisonburg, Va.	
12. CITIZEN OF WHAT COUNTRY? USA.				13. FATHER'S NAME Sayler Smith			
14. MOTHER'S MAIDEN NAME Mildred Toliver				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 220-30-9656				17. INFORMANT Address Hagerstown Md. Mrs Mildred Smith 123 W Bethel St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Gun shot. Wound Head DUE TO 981X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) instant DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Entire face blown off by shot gun					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 6 p. m. 4-17 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown Washington Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dr. J. W. L. Smith Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. F. W. L. Smith Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-20-1957		22c. NAME OF CEMETERY OR CREMATORY New Town Cemetery		22d. LOCATION (City, town, or county) (State) Harrisonburg, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr. Hagerstown Md				24a. REC'D BY REGISTRAR Apr 22, 1957		24b. REGISTRAR'S SIGNATURE B. H. Bowers	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF TEXAS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. F.

APR 24 1957

RECEIVED

VS. A15ME(5)
SM 9/55

4517

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.		c. LENGTH OF STAY IN lb 13 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 51 Harmon Alley				d. STREET ADDRESS 1 51 Harmon Alley		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carl		First Franklin		Middle Broadus		Last	
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1 1923	
9. AGE (In years last birthday) 34 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Luray, Va.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Casper Broadus				14. MOTHER'S MAIDEN NAME Virginia Sire			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. 578-24-1428			
17. INFORMANT John Broadus				Address Hagerstown, Md 673 Forest Drive.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) gun shot wound of head 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Enter top of head blown off by shot gun 20c. TIME OF INJURY Hour 6:14 Month, Day, Year 4-17 1957 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Hagerstown Washington Md (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . ACTUAL SIGNATURE Dr. E. W. Little M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Dr. E. W. Little ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4-21-1957 22c. NAME OF CEMETERY OR CREMATORY Family Cemetery 22d. LOCATION (City, town, or county) (State) Luray Va. 23. FUNERAL DIRECTOR'S SIGNATURE John R. Watson Jr. ADDRESS Hagerstown Md 24a. REC'D BY REGISTRAR Apr 22 1957 24b. REGISTRAR'S SIGNATURE Wesley Bowers							

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 24 1957

RECEIVED

4568

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Md.</u>				c. LENGTH OF STAY IN 1b <u>53 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>209 N. Conococheague Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Abraham</u> Last <u>Buharp</u>				4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23 1882</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>24</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baler Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tannery</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Buharp</u>				14. MOTHER'S MAIDEN NAME <u>Betty Knable</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-01-9968</u>		17. INFORMANT <u>N. Conococheague St # 209</u> <u>Mrs. Irene Abraham Buharp Williamsport, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>427/57</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>May</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>427/57</u>	
20f. (City or town) <u>Williamsport, Md.</u>				20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>4/27/57</u> to <u>4/30/57</u> , that I last saw the deceased alive on <u>4/27/57</u> , and that death occurred at <u>209 N. Conococheague St.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Ralph E. Young</u> M.D. <u>Williamsport, Md.</u> <u>4/30/57</u>							
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>				22b. DATE THEREOF <u>June 1-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hiverview Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Williamsport Md.</u>				22e. (State) <u></u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Reaf</u>				ADDRESS <u>Williamsport, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>May 1-1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>E. Lee McElroy</u>			

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 3 1957

BUREAU V. I.

4518

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 20 West Franklin St		d. STREET ADDRESS 20 West Franklin St	
3. NAME OF DECEASED (Type or print) FRANK NEWTON BYWATERS		4. DATE OF DEATH Month April Day 16 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 61 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Home Construction Corp		10b. KIND OF BUSINESS OR INDUSTRY Luray Va.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George E. Bywater		14. MOTHER'S MAIDEN NAME Rebecca Gouchenour	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 212-03-1398	
17. INFORMANT Mrs Lydia Bywaters		Address 20 W. Franklin St Hagerstown Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Esophagus (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 2m		INTERVAL BETWEEN ONSET AND DEATH 6 2m	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-1-56 , 19 56 , to 4-16 , 19 57 , that I last saw the deceased alive on 4-13-57 , 19 57 , and that death occurred at 4-16 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE E. F. Ditto Jr		DATE SIGNED 4/18/57	
PHYSICIAN'S NAME (Type) E. F. Ditto Jr		DATE SIGNED 4/18/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/19/57	22c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery	22d. LOCATION (City, town, or county) (State) Boonsboro Wash. Co Md
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR Apr. 20, 1957		24b. REGISTRAR'S SIGNATURE Chas H. Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for a burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 302

01520

4519

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>c3 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Martin Manor Convalescent Home</u>		d. STREET ADDRESS <u>800 Washington Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>BARTON</u> Last <u>CARLISLE</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>19 57</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 16, 1867</u>
9 AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>6</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11 BIRTHPLACE (State or foreign country) <u>Petersville, Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert B. Carlisle</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Garrett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Grace C. Stout</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Renal Disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Indetermin-</u> <u>ate</u> <u>Indetermin-</u> <u>ate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 24, 1957</u> , to <u>April 22, 1957</u> , that I last saw the deceased alive on <u>April 16, 1957</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>100 Professional Arts. Bldg. 4-24-57</u> DATE SIGNED <u></u>			
ACTUAL SIGNATURE <u>William T. Layman, M.D.</u>		M.D. <u>100 Professional Arts. Bldg. 4-24-57</u>	
PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/25/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Penner</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>Apr. 22, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frank H. Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 1 1957

RECEIVED

4520

CERTIFICATE OF DEATH

Reg. Dist. No.

01521
302

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. LENGTH OF STAY IN 1b 62 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 408 Summit Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mrs. Hannah Middle Mc Coy Last Carson		4. DATE OF DEATH Month April Day 16 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11 1873
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 10 Days 4 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Williamsport Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Walter B. Mc Coy		14. MOTHER'S MAIDEN NAME Clara Ardinger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. J. Howard Rohrer		Address 408 Summit Ave. Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe Arterio-sclerotic Cardiovascular disease with myocardial failure DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH 10 1/4 hr
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 15, 1956, to April 16, 1957, that I last saw the deceased alive on April 15, 1957, and that death occurred at 8:30 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE F. F. Lusby		ADDRESS (Street, city or town, state) M.D. 2301 N. Roman	
PHYSICIAN'S NAME (Type) F. F. Lusby		DATE SIGNED 17957	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF April 19-57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 22 1957

BUREAU V. E.

CERTIFICATE OF DEATH

Reg. Dist. No. 302

4562

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE Maryland b COUNTY Washington	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg Md.		c LENGTH OF STAY IN lb 17 yrs.	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION E. Antietam Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Charlotte Agnes Clapp		4 DATE OF DEATH Month Day Year April 12 1957	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 1898 Aug. 17 1892
9 AGE (In years last birthday) 58		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min 7 25	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Room Clerk		10b KIND OF BUSINESS OR INDUSTRY Hotel	
11 BIRTHPLACE (State or foreign country) Dargan Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A	
13 FATHER'S NAME John W. Echelberger		14 MOTHER'S MAIDEN NAME Margaret Hoffman	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16 SOCIAL SECURITY NO 214-09-2397	
17 INFORMANT Mrs. J. G. Malone		Address Sharpsburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 181X Infiltrating carcinoma of the urethra and bladder DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 8 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I attended the deceased from Sep. 1 1956 to 4/12/57, 19 that I last saw the deceased alive on 4/12/57, 19 and that death occurred at 5 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Walter H. Shealy M.D. Sharpsburg, Md. 4/15/57			
ACTUAL SIGNATURE Walter H. Shealy M. D.			
PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.			
22a BURIAL, CREMATION, REMOVAL (Specify) Burial	22b DATE THEREOF April 12-57	22c NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	22d LOCATION (City, town or county) (State) Sharpsburg Md.
23 FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Williamsport, Md.		24a REC'D BY REGISTRAR DATE 4/15/57	24b REGISTRAR'S SIGNATURE E. G. Boyer

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1967

RECEIVED

4570 CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wash. Co.</u>		MARYLAND		STATE <u>W. Va.</u>		COUNTY <u>Berkeley</u>	
CITY OR TOWN <u>San Mar</u>		LENGTH OF STAY (in this place) <u>5 MONTHS</u>		CITY OR TOWN <u>Martinsburg</u>		(if rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fahrney Keedy Memorial Home</u>				STREET ADDRESS <u>410 West King Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u> (Middle) <u>Susan</u> (Last) <u>Clendening</u>				(Month) <u>April</u> (Day) <u>6</u> (Year) <u>1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>white</u>	<u>single</u>	<u>12 March 1884</u>	<u>73</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>				<u>West Virginia</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Daniel Wright</u>				<u>Margaret Shoemaker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>unknown</u>		<u>Mrs. Charles Kantner</u> <u>115 N. Alabama Ave., Mtbg. W. Va.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cardiovascular Collapse</u>						<u>mm.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Vas. Accident</u>						<u>hrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>arteriosclerosis</u>						<u>hrs.</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-6-57</u> , 19 <u>57</u> , to <u>4-6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2-6</u> , 19 <u>57</u> , and that death occurred at <u>7 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Louis S. Sudd</u>				ADDRESS (Street, city, town, state)			
				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9 Apr. 1957</u>		<u>Middleway, W. Va.</u>		<u>Middleway, W. Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>4-9-57</u>		<u>John H. Baird</u>		<u>East Funeral Home Boonsboro Md</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED
APR 11 1957
BUREAU V. S.

4571

CERTIFICATE OF DEATH

Reg. Dist. No.

04524
304

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock</u>				c. LENGTH OF STAY IN 1b <u>40 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>27 Brent Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Irene</u> Last <u>Clingerman</u>				4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/15/1879</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>8</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Michael M. Door</u>				14. MOTHER'S MAIDEN NAME <u>Mary J. Divelbliss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-24-5272</u>		17. INFORMANT <u>Emory C. Clingerman</u> Address <u>Hancock, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>143X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/20/57</u> 19 <u>57</u> , to <u>4/23/57</u> 19 <u>57</u> , that I last saw the deceased alive on <u>4/23/57</u> 19 <u>57</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>John Wilson</u> M.D.				ADDRESS (Street, city or town, state) <u>Hancock, Maryland</u>		DATE SIGNED <u>4/24/57</u>	
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/27/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Christian</u>		22d. LOCATION (City, town, or county) (State) <u>Artemas, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Honored & Elmer Hancock</u>				24a. REC'D BY REGISTRAR <u>DATE 4/24</u>		24b. REGISTRAR'S SIGNATURE <u>Det Veller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 3 1957

BUREAU V. E.

4521

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>3 Mos</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>345 No Potomac st</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ANNA</u> First <u>BELLE</u> Middle <u>COFFMAN</u> Last		4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1957</u> 19		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 2 1872</u> 9. AGE (In years lost birthday) <u>85</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash. Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin Bostetter</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Sprecher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Address <u>Mrs Frances Odendhal 2 Roessner Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Hypertensive vascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 mo</u> <u>4 yrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1</u> , 19 <u>57</u> , to <u>April 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 27</u> , 19 <u>57</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>214 N. Potomac St.</u> DATE SIGNED <u>May 30 1957</u> ACTUAL SIGNATURE <u>W. H. Coffman</u> M.D. <u>Hagerstown, Md.</u> PHYSICIAN'S NAME (Type) <u>W. H. Coffman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>Apr. 30 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Coffman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 2 1937

BUREAU V. S.

4522

CERTIFICATE OF DEATH

Dr Wells

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 4 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 137 So Locust St				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 137 So Locust e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANK Middle ALVIN Last COSS				4. DATE OF DEATH Month April Day 26 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30 1890	
9. AGE (In years last birthday) 66		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. Express Clerk		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Chewsville Wash. Co Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Samuel Coss			
14. MOTHER'S MAIDEN NAME Rose Arthur				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 714-05-6867		17. INFORMANT Margaret Coss 137 So Locust St					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic coronary heart disease DUE TO (b) acute coronary occlusion DUE TO (c) Interval between onset and death: 1hr							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	
20f. (City or town) Hagerstown				20g. (County) Washington		20h. (State) Md.	
21. I certify that I attended the deceased from October, 1940 to April 26, 1957 that I last saw the deceased alive on April 1, 1957 , and that death occurred at 1:45 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Robert Wells				M.D. 115 N. Potomac Street			
PHYSICIAN'S NAME (Type) S. Robert Wells, M.D.				Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR Apr 30, 1957	
				24b. REGISTRAR'S SIGNATURE Frank Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

BUREAU V. S.

1 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04527

Reg. Dist. No. 302

4523

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>MINUTES</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON COUNTY HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> d. STREET ADDRESS <u>SOUTH MAIN STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HATTIE</u> Middle <u>S.</u> Last <u>CRONISE</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>AUGUST 28 1898</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FLORIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>		9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min <u> </u>			
11. BIRTHPLACE (State or foreign country) <u>BOONSBORO WASH.CO.MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>ESBY CRONISE</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214 36 0322</u>		17. INFORMANT <u>LEO CRONISE BOONSBORO WASH.CO.MD.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u>19</u> Hour <u> </u> a. m. <u> </u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>4/19/57</u>			
EXAMINER'S NAME (Type) <u>J. B. [Signature]</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
22b. DATE THEREOF <u>APRIL 23 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) <u>BOONSBORO WASH.CO.MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul-June Hous</u>				24a. REGD BY REGISTRAR <u>Apr 24 1957</u>			
ADDRESS <u>Boonsboro Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>			

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 3

APR 25 1957

RECEIVED

4572

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cascade</u>				c. LENGTH OF STAY IN 1b <u>36 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>M.</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/9/1904</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Lantz, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Lawson P. Poole</u>			
14. MOTHER'S MAIDEN NAME <u>Annie Florence Ott</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>John W. Davis</u> Address <u>Cascade, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Cardiac failure =</u> <u>444X</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1-1 1/2 hrs.</u> <u>2-5 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>10 April</u> , 1957, to <u>10 April</u> , 1957, that I last saw the deceased alive on <u>10 April</u> , 1957, and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Harry Young, Jr. M.D.</u> PHYSICIAN'S NAME (Type) <u>Blue Ridge Summit Pa 7-11-57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lantz, Md. R.D.1 Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Z. Gove</u> ADDRESS <u>Waynesboro, Pa.</u>				24a. REC'D BY REGISTRAR <u>APR 15 1957</u>		24b. REGISTRAR'S SIGNATURE <u>H. J. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

Dr. Binkford

4524

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown. Md.	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		d. STREET ADDRESS 1742 Gordon Road	
3. NAME OF DECEASED (Type or print) First BLOICE Middle COSMO Last DAVISON		4. DATE OF DEATH Month April Day 25 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1899
9. AGE (In years last birthday) yrs. 57		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director Of Service		10b. KIND OF BUSINESS OR INDUSTRY Greenville Darke Co	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Claude E. Davison		14. MOTHER'S MAIDEN NAME Emma Medford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 376-05-8971	
17. INFORMANT Corabelle G. Davison		Address 1742 Gordon Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic heart disease DUE TO (c) cardiac failure		INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 6 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old myocardial infarction			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 13 Mar. 1957 to 25 April 1957 , that I last saw the deceased alive on 25 April 1957 , and that death occurred at 9:28 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Richard T. Binkford M.D. 26 APRIL 1957			
ACTUAL SIGNATURE Richard T. Binkford		PHYSICIAN'S NAME (Type) RICHARD T. BINKFORD, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/57	
22c. NAME OF CEMETERY OR CREMATORY Greenville Cemetery		22d. LOCATION (City, town, or county) (State) Greenville Darke Co Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		24a. REC'D BY REGISTRAR Apr. 30 1957	
ADDRESS Hagerstown Md.		24b. REGISTRAR'S SIGNATURE Charles Bowers	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar in a burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4525

CERTIFICATE OF DEATH

Reg. Dist. No. 302 04530

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Washin ton	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 320 North Locust Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS Hagerstown, Md.	
3. NAME OF DECEASED (Type or print) First Middle Last VELENCIA ANN DICK		4. DATE OF DEATH Month Day Year April 26 19 57	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leon S. Dick		14. MOTHER'S MAIDEN NAME Beverly Ann Renner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Leon S. Renner		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 7600 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemorrhage into supratentorial DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 18 hrs 15 hrs			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 PM 25 Apr 1957, to 10 AM 26 Apr 1957, that I last saw the deceased alive on 26 Apr 1957, and that death occurred at 10 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE F. F. Lusby		ADDRESS (Street, city or town, state) DATE SIGNED 230 Potomac 26 Apr 57	
PHYSICIAN'S NAME (Type) F. F. Lusby			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/27/1957	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Rieger		24a. REC'D BY REGISTRAR 29.1957 24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 1 1957

BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4573

CERTIFICATE OF DEATH

04531

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MAPLEVILLE</u> c. LENGTH OF STAY IN 1b <u>432 YRS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOONSBORO MD. R. 2</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 MAPLEVILLE</u> d. STREET ADDRESS <u>1 RURAL</u> • IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JACOB</u> Middle <u>M.</u> Last <u>EASTERDAY</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCTOBER 25 1878</u> 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>BOONSBORO WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHRISTOPHER EASTERDAY</u>		14. MOTHER'S MAIDEN NAME <u>AMANDA HOUP</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. EDNA EASTERDAY</u>		Address <u>BOONSBORO WASH. CO. MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac vascular Disease</u> DUE TO (b) <u>arterio-sclerotic heart disease +</u> DUE TO (c) <u>Myocardial failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Min.</u> <u>no</u> <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lobar pneumonia 2 weeks</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 6, 1957</u> , to <u>April 6, 1957</u> , that I last saw the deceased alive on <u>April 6, 1957</u> , and that death occurred at <u>11:30 M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>119 E. Independence St</u> DATE SIGNED <u>9/8/57</u>			
ACTUAL SIGNATURE <u>Louis G. Gault</u> M.D.		PHYSICIAN'S NAME (Type) <u>Louis G. Gault M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>APRIL 10 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>East-Town Home</u>		ADDRESS <u>Boonsboro Md</u>	
24a. REC'D BY REGISTRAR <u>John H. Park</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Park</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
APR 11 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										04532	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 302	
1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>					c. LENGTH OF STAY IN 1b <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>238 Summit Ave - Hagerstown</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Died enroute to Wash. County Hospital</u>					d. STREET ADDRESS <u>238 Summit Avenue</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Henson</u> Last <u>Easterday</u>					4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1957</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unknown</u>		9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Thomas Charles Henson</u>					14. MOTHER'S MAIDEN NAME <u>Katherine Shirley</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT <u>Mr. Fride Henson</u>			Address <u>Room # 4 Shprehur, Md and</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of the liver (fatty infiltration)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic alcoholism</u> DUE TO (c) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>Under 24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u></u>		(County) <u></u> (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE <u>S. Robert Wells</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>4-2-57</u>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>April 3 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosehill Cemetery</u>			22d. LOCATION (City, town, or county) <u>Hagerstown, Maryland</u> (State) <u></u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. F. Williamsport, Md</u>						24a. REC'D BY REGISTRAR <u>Apr. 4. 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. F. Bowers</u>			

MEDICAL CERTIFICATION

BUREAU V. S.

APR 8 1957

RECEIVED

4527

CERTIFICATE OF DEATH

Reg. Dist. No.

04533
302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
c. LENGTH OF STAY IN 1b 80 YRS.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 109 S. POTOMAC ST.				d. STREET ADDRESS 109 S. POTOMAC ST.			
3. NAME OF DECEASED (Type or print) First HERMAN Middle RANDOLPH Last EAVEY				4. DATE OF DEATH Month APRIL Day 17 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/13/1870	
9. AGE (in years last birthday) 86 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED DENTIST				10b. KIND OF BUSINESS OR INDUSTRY OWN PRACTICE		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HENRY S. EAVEY				14. MOTHER'S MAIDEN NAME SARAH HOFFMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE		17. INFORMANT MR. HARRY R. EAVEY HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis in DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from JAN 1954 , to APRIL 17, 1957 , that I last saw the deceased alive on APRIL 16, 1957 , and that death occurred at 2:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Lloyd A. Hoffman M.D.				ADDRESS (Street, city or town, state) 214 N. Potomac St			
DATE SIGNED 4/18/57							
PHYSICIAN'S NAME (Type) Lloyd A. Hoffman				Hagerstown, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/19/57		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horne				ADDRESS Hagerstown, Md		24a. REC'D BY REGISTRAR 4/20/57	
				24b. REGISTRAR'S SIGNATURE Bessie Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4528

Item 2 Filed 1957-10-27

CERTIFICATE OF DEATH

Reg. Dist. No.

013202

1 PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>5 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quincy / Mt. Wolf, Pa.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>E. U. B. / Onababate / 1 / Home /</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rev. Frank</u> Middle <u>B.</u> Last <u>Emenheiser</u>				4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>19 57</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/22/1870</u>			
9. AGE (In years last birthday) <u>86</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		11. BIRTHPLACE (State or foreign country) <u>Lower Windsor, York, Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Benjamin Emenheiser</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Keller</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Ruth Spalding, York Haven, York Co, Pa.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>6/10X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prostate Hypertrophy</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 Month</u> <u>3 Months</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. <u>5</u> p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>March 24</u> , 19 <u>57</u> , to <u>April 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 28</u> , 19 <u>57</u> , and that death occurred at <u>2:25 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>832 Potomac Ave, Hagerstown, Md.</u> DATE SIGNED									
ACTUAL SIGNATURE <u>J. G. Warden</u>				M.D. <u>832 Potomac Ave, Hagerstown, Md.</u>					
PHYSICIAN'S NAME (Type) <u>J. G. Warden, M.D.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/30/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Rose</u>		22d. LOCATION (City, town, or county) (State) <u>York Pa.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Z. Gure</u>				ADDRESS <u>Waynesboro, Pa.</u>		24a. RECD BY REGISTRAR <u>Apr. 30, 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>Chas. Bowers</u>									

BUREAU V. B.

MAY 2 1957

RECEIVED

4529

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. STREET ADDRESS 821 Concord St.	
3. NAME OF DECEASED (Type or print) First ADA Middle BEAUFORT Last FAHRNEY		4. DATE OF DEATH Month April Day 29 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1869
9. AGE (In years last birthday) 87 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Luther Middlekauff		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. C.T. Hauver		Address 821 Concord St. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Fracture of left hip DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH April 29 April 25
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterial sclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Patient fell		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 4:30 p.m. Apr. 25 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Hagerstown, Wash. Md.		(County) (State)	
21. I certify that I attended the deceased from Apr. 26, 1957 , to Apr. 29, 1957 , that I last saw the deceased alive on April 29, 1957 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John J. Dobbie</i>		M.D. 115 King Street, Hagerstown, Md.	
PHYSICIAN'S NAME (Type) John J. Dobbie, M. D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 1, 1957	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR May 1, 1957	
24b. REGISTRAR'S SIGNATURE <i>Wm. C. Hoot</i>		24c. REGISTRAR'S SIGNATURE <i>Wm. C. Hoot</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAY 3 1957
BUREAU V. S.

4530

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn.</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle, Pa.</u>			
c. LENGTH OF STAY IN 1b <u>2 WKS</u>				d. STREET ADDRESS <u>26 North Carlisle st</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Walson</u> Last <u>Fletcher</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/25/1880</u>	
9. AGE in years last birthday <u>77</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mining</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Henry Fletcher</u>				14. MOTHER'S MAIDEN NAME <u>Martha E. Rowe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Vol. no. or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>198-0-3826</u>			
				17. INFORMANT <u>Mrs. Julia J. Fletcher, Greencastle, Pa.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of colon</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>4/1/57</u> , 19 <u>57</u> , to <u>4/20/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/20/57</u> , 19 <u>57</u> , and that death occurred at <u>12:35 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. O. Brewer</u> M.D.				DATE SIGNED <u>4/22/57</u>			
PHYSICIAN'S NAME (Type) <u>W. O. Brewer, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/23/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Greencastle Franklin Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stanley M. Zimmerman, Greencastle, Pa.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>Apr. 23/1957</u>		24b. REGISTRAR'S SIGNATURE <u>East Rovers</u>	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 25 1957

RECEIVED

MEDICAL CERTIFICATION

VS A15 (4)
ISM 9/55

RECEIVED

APR 28 1957

BUREAU V. S.

4532

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>36 Avalon Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE</u> <u>CECILIA</u> <u>GERKINS</u>				4. DATE OF DEATH Month Day Year <u>April</u> <u>7</u> <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25, 1908</u>		9. AGE (In years last birthday) <u>48</u> yrs	IF UNDER 1 YEAR Months <u>15</u> Days <u>12</u>	IF UNDER 24 HRS Hours <u>12</u> Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Midland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Thomas Farrell</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth O'Rourke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>Charles M. Gerkins Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia bronchial</u> <u>11.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Constrictive heart failure</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had Ventral hernia 3 April</u>							INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>24 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>28 March, 1957</u> , to <u>7 April, 1957</u> , that I last saw the deceased alive on <u>7 April, 1957</u> , and that death occurred at <u>11:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. H. B. Bouchard</u> M.D.				ADDRESS (Street, city or town, state) <u>115 W. Washington</u>		DATE SIGNED <u>4/8/57</u>	
PHYSICIAN'S NAME (Type) <u>E. H. B. Bouchard</u>				<u>Hagerstown, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/10/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Franklin Rieger</u>				ADDRESS <u>Hagerstown, Maryland</u>		24a. RECEIVED BY REGISTRAR <u>Apr. 9, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
APR 11 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

. 4533

CERTIFICATE OF DEATH

Reg. Dist. No.

04539

302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 2 WEEKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 18 POTOMAC STREET			
3. NAME OF DECEASED (Type or print) First EVA Middle EDNA Last GILBERT				4. DATE OF DEATH Month APRIL Day 18 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 26 1882	
9. AGE (In years last birthday) 74 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MONROE WASH. CO. MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ALFRED C. HUFFER		14. MOTHER'S MAIDEN NAME SARAH TOMS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT D. GARFIELD GILBERT BOONSBORO MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1957 , to April 18, 1957 , that I last saw the deceased alive on April 18, 1957 , and that death occurred at Boonsboro , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Boonsboro Md. DATE SIGNED 4/21/57							
ACTUAL SIGNATURE G. W. Williams M.D.				PHYSICIAN'S NAME (Type) G. W. Williams			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		APRIL 22 1957		BOONSBORO CEMETERY		BOONSBORO WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE East Funeral Home Boonsboro md.				24a. RECEIVED BY REGISTRAR APR 24 1957		24b. REGISTRAR'S SIGNATURE Frank Bowers	

MEDICAL CERTIFICATION

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar's office for burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 23 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

302

4534

1 PLACE OF DEATH a COUNTY <u>Washington</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Washington</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>				c LENGTH OF STAY IN 1b <u>1 week</u>			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>CALVIN</u> Last <u>GOOD</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1957</u>			
5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>Aug. 20 1875</u>	
9 AGE (In years last birthday) <u>81</u> yrs		IF UNDER 1 YEAR Months <u>8</u> Days <u>0</u>		IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13 FATHER'S NAME <u>Harvey Good</u>				14 MOTHER'S MAIDEN NAME <u>Elizabeth Mowan</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>No</u>				16 SOCIAL SECURITY NO <u>216-09-3242</u>			
17 INFORMANT <u>Mrs. Dora Good</u>				Address <u>Hagerstown Md. RFD #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Atypical</u> <u>492X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>420.0</u> (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Arteriosclerotic Heart Disease, Malignant destruction of C-2 vertebra</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day Year Hour a. m. p. m. <u>19</u>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1 April</u> , 19 <u>57</u> , to <u>April 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>20 April</u> , 19 <u>57</u> , and that death occurred at <u>10:47</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>28 W. Potomac Street</u> DATE SIGNED <u>22 April 57</u> ACTUAL SIGNATURE <u>Paul Haak</u> M.D. <u>Williamstown, Maryland</u> PHYSICIAN'S NAME (Type) <u>PAUL HAACK</u>							
22a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 24-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Legg</u>				23a ADDRESS <u>Williamstown, Md</u>		23b REC'D BY REG STRAR <u>Apr. 23, 1957</u>	
23c REGISTRAR'S SIGNATURE <u>Robert L. Legg</u>				23d REGISTRAR'S SIGNATURE <u>Robert L. Legg</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

APR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4574 CERTIFICATE OF DEATH

04541
Reg. Dist. No. 323

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHARLTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHARLTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NONE</u>		d. STREET ADDRESS <u>NONE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>COURTNEY</u> <u>CYRUS</u> <u>GROSH</u>		4. DATE OF DEATH Month Day Year <u>APRIL</u> <u>1</u> <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 24, 1867</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>CLEAR SPRING, MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JOHN GROSH</u>		14. MOTHER'S MAIDEN NAME <u>MARY JONES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>COURTNEY GROSH JR.</u>		Address <u>CLEAR SPRING, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chr. Endocarditis</u> <u>4</u> . <u>4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterial Sclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 2</u> , 19 <u>57</u> , to <u>April 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Mar 31</u> , 19 <u>57</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer, M.D.</u>		DATE SIGNED <u>4/2/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>APRIL 3, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>CLEAR SPRING, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u>		24a. REC'D BY REGISTRAR <u>April 4-57</u>	
ADDRESS <u>CLEAR SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Carol Ann M. M. M.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 9 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar from whom burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4535

CERTIFICATE OF DEATH

Reg. Dist. No.

04542

302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>8 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JAMSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON COUNTY HOSPITAL</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES HARVEY GRUBBS</u>				4. DATE OF DEATH Month Day Year <u>APRIL 13 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-18-1863</u>	
9. AGE (In years last birthday) yrs <u>93</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>BUSHROD W. GRUBBS</u>				14. MOTHER'S MAIDEN NAME <u>MARY GORE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>L</u>		16. SOCIAL SECURITY NO. <u>L</u>		17. INFORMANT Address <u>EMORY GRUBBS (SON) JAMSVILLE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>uremia</u>							<u>2-3 weeks</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>nephrosclerosis</u>							<u>years</u>
(c) <u>Generalized arteriosclerosis</u>							<u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recent prostate & hemorrhoid operation; pneumonia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>5 April 1957</u> to <u>13 April 1957</u> , that I last saw the deceased alive on <u>12 April 1957</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard F. Binford</u> M.D.				ADDRESS (Street, city or town, state) <u>Hagerstown Md, 13 April 1957</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD F. BINFORD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-16-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>KEMPTOWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>KEMPTOWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Tolson</u>				ADDRESS <u>New Market Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 22 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas. A. Brown</u>			

BUREAU V. S.

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01543

302

4536

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2417 PENNA AVE. HAGERSTOWN				c. LENGTH OF STAY IN 1b 3 MO.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF (Type or print) MARY HANNAH HAMILTON				4. DATE OF DEATH APRIL 15, 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 6, 1881	9. AGE (In years last birthday) 75 yrs.	F UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME THOMAS JONES			
14. MOTHER'S MAIDEN NAME ELIZABETH SAGER				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. NONE				17. INFORMANT WALTER M. HAMILTON Address ROBINSON ICE & COLD STG., WINCHESTER, VA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the uterus DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 25, 1957 , to April 15, 1957 , that I last saw the deceased alive on April 15, 1957 , and that death occurred at 2:10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Paul F. Webster</i>				ADDRESS (Street, city or town, state) 242 East Baltimore Street			
PHYSICIAN'S NAME (Type) Paul F. Webster, M.D.				Greencastle, Pennsylvania			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APR. 18, 1957		22c. NAME OF CEMETERY OR CREMATORY HUDSON'S CROSS ROADS		22d. LOCATION (City, town, or county) (State) SHENADOAH CO., VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lauren P. Jones, Winchester, Va.</i>				24a. REC'D BY REGISTRAR APR 24 1957		24b. REGISTRAR'S SIGNATURE <i>Chas. H. Bowers</i>	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
APR 24 1957
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4575

CERTIFICATE OF DEATH

04544

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro				c. LENGTH OF STAY IN 1b 4 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 312 N. Main St				d. STREET ADDRESS 312 N. Main St.			
3. NAME OF DECEASED (Type or print) First Irvin Middle Ira Last Harbaugh				4. DATE OF DEATH Month April Day 30 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1876		9. AGE (In years last birthday) 80 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.	
13. FATHER'S NAME Calvin Harbaugh				14. MOTHER'S MAIDEN NAME Catherine McClain			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-12-0513		17. INFORMANT Address Mrs. Ralph Hutzel Boonsboro Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Generalized Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with cerebral thrombosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July , 1945, to 30 apr , 1957, that I last saw the deceased alive on 28 apr , 1957, and that death occurred at 8:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 230 N Potomac DATE SIGNED 1 May 57 ACTUAL SIGNATURE F. F. Lusby M.D. Hagerstown Md PHYSICIAN'S NAME (Type) F. F. Lusby							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-3-57		22c. NAME OF CEMETERY OR CREMATORY Luthern Cemetery		22d. LOCATION (City, town, or county) (State) Boonsboro Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DATE May 4 57	
				24b. REGISTRAR'S SIGNATURE John H. Baird Jr			

BUREAU V. A.

MAY 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

4537

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) STATE <u>New York</u> COUNTY <u>Kings</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 Hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn 9</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. County Hospital</u>				d. STREET ADDRESS <u>547 79th St</u>			
3. NAME OF DECEASED (Type or print) First <u>JOSEPHINE</u> Middle <u>FLORENCE</u> Last <u>HENRICKSEN</u>				4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1957 19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 20 1902</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>		11. BIRTHPLACE (State or foreign country) <u>No Record</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>No Record</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>-----</u>		17. INFORMANT <u>Unable to Locate Christopher H. henricksen</u> Address <u>547 79th St Brooklyn N.Y.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull</u> DUE TO <u>Closed fracture lt forearm</u> (b) <u>Multiple lacerations of both thighs</u> DUE TO <u>Contusions to body - Hemorrhage and shock</u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>3hrs 20 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in automobile that hit a tractor trailer</u>					
20c. TIME OF INJURY Month, Day, Year <u>6:35 AM Apr. 26 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Rural Hagerstown Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-27-57</u>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green-Wood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn Kings Co New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>Apr. 30 1957</u>		24b. REGISTRAR'S SIGNATURE <u>S. Robert Wells</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 48 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

BUREAU V. S.

MAY 2 1957

RECEIVED

CERTIFICATE OF DEATH

Dr. Harshman

Reg. Dist. No. 302

4538

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown #4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>Cearsfoss Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Josephine</u> Last <u>Hollinger</u>		4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 5/1869</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE (In years last birthday) <u>87</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Cearsfoss, Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Henry Spiokler</u>	
14. MOTHER'S MAIDEN NAME <u>Kathrine Gabriel</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Daniel Hollinger</u> Address <u>Cearsfoss Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO <u>Arteriosclerosis - Cerebral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10/14/57 Tumor Cerebral Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 31</u> , 19 <u>57</u> , to <u>April 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 4</u> , 19 <u>57</u> , and that death occurred at <u>11</u> <u>PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>M.D. 159 W. Washington St., Hagerstown, Md.</u> DATE SIGNED <u>4/5/57</u>			
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>		PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cearsfoss, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		24a. REC'D BY REGISTRAR <u>Apr. 8, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Phasht Bowers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. S.

APR 10 1907

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4576

CERTIFICATE OF DEATH

Reg. Dist. No.

44547
3027

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Beaver Creek		c. LENGTH OF STAY IN 1b 1 yr 6 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural # 1 Beaver Creek			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R # 1 - Hagerstown				d. STREET ADDRESS Hagerstown		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary McMahon Hughes			4. DATE OF DEATH Month Day Year April 13 19 57				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1871		9. AGE (In years lost birthday) 85 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael McMahon				14. MOTHER'S MAIDEN NAME Priscilla Jane Daley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Ethel Snyder-(niece)- Beaver Creek, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Adenocarcinoma of cecum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Hour a. m. p. m. None 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) -		(County) (State) - -
21. I certify that I attended the deceased from none, 19, to 19, that I last saw the deceased alive on 12, and that death occurred at 6:02 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Robert Wells		M.D. S. Robert Wells, M.D.		ADDRESS (Street, city or town, state) 115 N. Potomac Street Hagerstown, Maryland		DATE SIGNED 4-13-57	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/57		22c. NAME OF CEMETERY OR CREMATORY Gruid Ridge Cem.		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Apr. 16, 1957		24b. REGISTRAR'S SIGNATURE Charles Powers	

RECEIVED

APR 1 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04548

4539

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>5 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON COUNTY HOSPITAL</u>				d. STREET ADDRESS <u>1 BOONSBORO MD. R. 2.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>DOROTHY ELIZABETH HUTZELL</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 23-1933-23-3-12</u>	
9. AGE (In years last birthday) <u>23</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MT. LENA WASH. CO. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ADAM GREEN</u>		14. MOTHER'S MAIDEN NAME <u>SOUDERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO.</u>				16. SOCIAL SECURITY NO <u>217-32-7329</u>			
17. INFORMANT <u>WILLIAM M. HUTZELL</u>				Address <u>BOONSBORO MD. R. 2.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>420.0</u> DUE TO <u>Acute heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO <u>Arteriosclerotic heart disease</u> (c) INTERVAL BETWEEN ONSET AND DEATH <u>4/1/57</u> <u>10 days</u> <u>1 year</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dwarfism with acute deformity of the thoracic cage</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>She had a cesarean on 3/3/57 for full term baby.</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4/1/57</u> , 19 <u>57</u> to <u>4/5/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>4/4/57</u> , 19 <u>57</u> , and that death occurred at <u>9:15 A.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. H. Shealy</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Chesapeake, Md. 4/3/57</u>			
PHYSICIAN'S NAME (Type) <u>W. H. Shealy M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL-8-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. LENA CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MT. LENA WASH. CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>				ADDRESS <u>BOONSBORO MD.</u>		24a. REC'D BY REGISTRAR <u>APR 11 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Phas H Bowers</u>							

BUREAU V. S.

APR 15 1957

RECEIVED

4540

CERTIFICATE OF DEATH

Dr. Novenstein

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b One week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Cty. Hospital				d. STREET ADDRESS 435 Virginia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Abraham Jacobson		4. DATE OF DEATH Month Day Year April 6 19 57					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 15 1891	9. AGE (In years last birthday) 65 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Store		11. BIRTHPLACE (State or foreign country) Latvia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Hirsh Jacobson				14. MOTHER'S MAIDEN NAME Frances Jacobson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215 18-1586		17. INFORMANT Address Herbert Jacobson			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Heart Disease DUE TO (c) _____		435 Virginia Ave.		INTERVAL BETWEEN ONSET AND DEATH March 24-1957			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 27, 1957 , to April 6, 1957 , that I last saw the deceased alive on April 5, 1957 , and that death occurred at 1:07 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Sidney Novenstein M.D. 4-6-57							
ACTUAL SIGNATURE Sidney Novenstein		PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/7/57		22c. NAME OF CEMETERY OR CREMATORY King David Mem. Cem.		22d. LOCATION (City, town, or county) (State) Falls Church, Fairfax Ct. Va	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md.				24a. REC'D BY REGISTRAR Apr. 8, 1957		24b. REGISTRAR'S SIGNATURE Glenn Bower	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
APR 11 1957
BUREAU V. S.

4577

CERTIFICATE OF DEATH

Reg. Dist. No.

311

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport				c. LENGTH OF STAY IN 1b 1 yr 11 days			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Williamsport Sanitarium				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
4. NAME OF DECEASED (Type or print) First Fannie Middle Josephine Last Keller				4. DATE OF DEATH Month 4 Day 28 Year 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 4, 1866	
9. AGE (In years last birthday) 90 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home duties				10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Middletown, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Nikirk				14. MOTHER'S MAIDEN NAME Mary M. Bechtol			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO none		17. INFORMANT Paul Keller		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia 4' x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 21 April , 19 57 , to 28 April , 19 57 , that I last saw the deceased alive on 21 April , 19 57 , and that death occurred at 11:30 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Paul Haak M.D.				28 W. Falmace St 30 April 57			
PHYSICIAN'S NAME (Type) PAUL HAAK, M.D.				Williamsport, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5-1-57		22c. NAME OF CEMETERY OR CREMATORY Rest Haven		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR May 2-1957	
				24b. REGISTRAR'S SIGNATURE E Lee McElroy			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAY 6 1957
BUREAU V. J.

4541

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 40 Yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 49 East Washington St				d. STREET ADDRESS 49 East Washington St				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLARENCE				Middle -----				Last LAMAR			
4. DATE OF DEATH Month April				Day 22				Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 5 1882		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier Retired				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Marene LaMar				14. MOTHER'S MAIDEN NAME Anne Snyder							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. none				17. INFORMANT Address Miss Beda LaMar 49 E. Washington St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Hypertension, Cerebral Vascular Disease (c) INTERVAL BETWEEN ONSET AND DEATH 5 yrs											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2-7- , 19 55 , to 4-22- , 19 57 , that I last saw the deceased alive on 4-10-57 , 19 57 , and that death occurred at 4 M., from the causes and on the date stated above.											
ACTUAL SIGNATURE Dr E W Ditto Jr				M.D. Hagerstown Md				DATE SIGNED 4-27-57			
PHYSICIAN'S NAME (Type) Dr E W Ditto Jr				ADDRESS (Street, city or town, state) Hagerstown Md				DATE SIGNED 4-27-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/24/57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				22d. LOCATION (City, town, or county) Hagerstown Wash. Co Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.				24a. REC'D BY REGISTRAR Apr 25, 1957		24b. REGISTRAR'S SIGNATURE Chas H Bowers	

RECEIVED

APR 10 1957

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 File

4578

CERTIFICATE OF DEATH

Dr Conrad 4552
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Charles City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Breathedsaville				c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Md State Reformatory for Males				d. STREET ADDRESS 2228 W. North Avenue House of Correction			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ROLAND First Middle Last				4. DATE OF DEATH April 26 1957 19			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH April 7 1921 36 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roland Lancaster Sr				14. MOTHER'S MAIDEN NAME Leona Lancaster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 577-22-9385		17. INFORMANT Mrs Leona Lancaster 3251 W. Mount Ave Baltimore Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Relapsing Tuberculosis CC & X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 6 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Apr 23 , 19 57 , to Apr 26 , 19 57 , that I last saw the deceased alive on Apr 24 , 19 57 , and that death occurred at 12:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 137 W. Washington DATE SIGNED Apr 26 57 ACTUAL SIGNATURE Robert P. Conrad M.D. Hagerstown, Md PHYSICIAN'S NAME (Type) Robert P. Conrad							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/30/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore Natl Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR APR 29 1957	
				24b. REGISTRAR'S SIGNATURE Chas. Bowyer			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 31

PR 29 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4579

CERTIFICATE OF DEATH

Reg. Dist. No.

01553

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CLEAR SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CLEAR SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CLEAR SPRING M' 2</u>				d. STREET ADDRESS <u>CLEAR SPRING ST 2</u>			
3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle <u>MAY</u> Last <u>LEASURE</u>				4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19, 1900</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK L. BLOYER</u>				14. MOTHER'S MAIDEN NAME <u>MINNIE WINTERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>George Leasure</u> Address <u>CLEAR SPRING ST 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 26, 1957</u> to <u>April 28, 1957</u> that I last saw the deceased alive on <u>April 28, 1957</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.				ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u> DATE SIGNED <u>4/29/57</u>			
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>MAY 1, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>STAIRS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark Clear Spring, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>May 2-57</u>		24b. REGISTRAR'S SIGNATURE <u>Joseph W. Murray</u>	

RECEIVED
MAY 6 1957
BUREAU V. S.

4542 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 18 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON CO. HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE LAST FRED LEIGH				4. DATE OF DEATH Month 4 Day 3 Year 19 7			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 4, 1910	
9. AGE (In years last birthday) 47 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) SEWING MACHINE		11. BIRTHPLACE (State or foreign country) BLDG. CONTRACTOR MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES K. LEIGH				14. MOTHER'S MAIDEN NAME CORA THOMAS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 213-12-7462		17. INFORMANT Mrs. Mary Leigh Address CLEAR SPRING, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 18 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from Mar 14, 1957, to April 3, 1957, that I last saw the deceased alive on April 2, 1957, and that death occurred at 3:08 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE David R. Brewer M.D.				ADDRESS (Street, city or town, state) Clear Spring Md. DATE SIGNED 4/3/57			
PHYSICIAN'S NAME (Type) David R. Brewer							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4/5/57		22c. NAME OF CEMETERY OR CREMATORY ROSS HILL		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark				ADDRESS Clear Spring, Md.		24a. REC'D BY REGISTRAR 4/5/57 24b. REGISTRAR'S SIGNATURE David R. Brewer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 8 1957

BUREAU V. S.

4543

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>124 Ruby Ave.</u>		d. STREET ADDRESS <u>124 Ruby Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Herbert</u> First <u>(no)</u> Middle <u>Lockley</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>4</u> Days <u>24</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sand blast mill</u>	
11. BIRTHPLACE (State or foreign country) <u>Boyce Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>George Lockley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-14-3597</u>	
17. INFORMANT <u>Lucy Lockley</u>		Address <u>124 Ruby Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> <u>4 yrs</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>4 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 9</u> , 19 <u>57</u> , to <u>April 24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>April 3</u> , 19 <u>57</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip J. Hirshman</u> M.D.		ADDRESS (Street, city or town, state) <u>154 W. Washington St. Hagerstown Md</u> DATE SIGNED <u>4/24/57</u>	
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-27-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Millwood Chapel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Millwood Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Watson</u>		ADDRESS <u>Hagerstown Md</u> 24a. REC'D BY REGISTRAR <u>4/28/57</u> 24b. REGISTRAR'S SIGNATURE <u>Chas H. Baewers</u>	

RECEIVED

APR 30 1957

BUREAU V. S.

4580

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Big Spring</u> c. LENGTH OF STAY IN 1b <u>75 Yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cove Road</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Big Spring</u> d. STREET ADDRESS <u>Cove Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>LUCY</u> Middle <u>MAY</u> Last <u>LONG</u>			4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15 1879</u>		9. AGE (In years last birthday) <u>77</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Sh. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Hart</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Bowers</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs Rosie Doyle Hagerstown Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>31X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>3 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 7, 1957</u> to <u>April 15, 1957</u> that I last saw the deceased alive on <u>April 14, 1957</u> , and that death occurred at <u>19</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u> DATE SIGNED <u>4/15/57</u>					
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.			PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Spring Furn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sh. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>			24a. REC'D BY REGISTRAR <u>April 17-57</u>		24b. REGISTRAR'S SIGNATURE <u>Joseph W. Miller</u>

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and any event within 72 hours after death.

RECEIVED

APR 22 1967

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4544

CERTIFICATE OF DEATH

Reg. Dist. No.

04558
302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
f. STREET ADDRESS 110 South Locust St.		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle VIRGINIA Last LUCE		4. DATE OF DEATH Month April Day 15 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1883
9. AGE (In years last birthday) 73 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Jamestown, Ohio.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Moses Starkey		14. MOTHER'S MAIDEN NAME Katherine O'Ferrall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Wm. Starkey		Address 1028 Columbia Rd. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio Sclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 15, 1957 to Apr. 17, 1957 and that I last saw the deceased alive on Apr. 15, 1957 , and that death occurred at 6 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J.H. Beachley M.D.		ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED Apr. 16, 1957	
PHYSICIAN'S NAME (Type) J.H. Beachley M.D.		221 W. Washington St. Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 18, 1957	22c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery	22d. LOCATION (City, town, or county) (State) Berryville Va.
23. FUNERAL DIRECTOR'S SIGNATURE Enders Funeral Home		ADDRESS Berryville, Va.	
24a. REC'D BY REGISTRAR Apr. 16, 1957		24b. REGISTRAR'S SIGNATURE Chas. H. Powers	

RECEIVED
APR 18 1957
BUREAU V. S.

4545

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 12 Hrs.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital			d. STREET ADDRESS Hancock Maryland.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Roy Middle Lee Last Lynch			4. DATE OF DEATH Month 4 Day 11 Year 19 57		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1.3.1898		9. AGE (In years last birthday) yrs. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Liquor Store		10b. KIND OF BUSINESS OR INDUSTRY Retail Liquor St.		11. BIRTHPLACE (State or foreign country) Fulton County Penna.	
13. FATHER'S NAME Paul Lynch		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
14. MOTHER'S MAIDEN NAME Martha Bridges					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 220-30-8825		17. INFORMANT Mrs Margaret Lynch Hancock Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 466X DUE TO Pulmonary Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis of Femoral Vein (c) None PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 0. 11. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from April 10, 1957 to April 11, 1957 that I last saw the deceased alive on April 11, 1957 , and that death occurred at 6:40 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE J.H. Beachley M.D.		DATE SIGNED APR 11 1957			
PHYSICIAN'S NAME (Type) J.H. Beachley					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4.14.57		22c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery	
22d. LOCATION (City, town, or county) Hancock Washington Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Honore F. Stone Hancock Md		ADDRESS Hancock Md		24a. REC'D BY REGISTRAR APR 16 1957	
24b. REGISTRAR'S SIGNATURE W. H. Powers					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with the registrar for a burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
APR 18 1957
BUREAU V. S.

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 FilmG211 4-23-57 et

4546

CERTIFICATE OF DEATH

Reg. Dist. No.

04561
30261

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Maryland, (X)</u>			
c. LENGTH OF STAY IN 1b <u>2 yrs.</u>				d. STREET ADDRESS <u>673 Pennsylvania Av.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>673 Pennsylvania Av.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Selena Kattie Willard</u>				4. DATE OF DEATH Month Day Year <u>4 11 1957</u>			
5 SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 1 1881</u>	
9 AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Falls Church, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>arteriosclerosis glaucoma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>1 hr.</u> <u>1 hr.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1956</u> to <u>April 11, 1957</u> that I last saw the deceased alive on <u>April 11, 1957</u> and that death occurred at <u>11 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip J. Hirshman</u> M.D.				DATE SIGNED <u>159 W. Washington St. Hagerstown Md 4/12/57</u>			
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-15-57</u>		<u>Woodlawn</u>		<u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John R. Watson Jr. Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>Apr 12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. L. Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 16 1957

RECEIVED

4581

CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAPLAND RURAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAPLAND RURAL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GAPLAND MD.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLARA Middle VIRGINIA Last MULLENDORE				4. DATE OF DEATH Month APRIL Day 9 Year 1957			
5. SEX F MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 11 1889	9. AGE (In years last birthday) 68 0 28	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) SAMPLES MANOR WASH. CO. MD. U.S.A.	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME JOHN F. MOATS			
14. MOTHER'S MAIDEN NAME ALICE CLINE				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NONE NONE			
16. SOCIAL SECURITY NO.				17. INFORMANT EARL D. MULLENDORE GAPLAND MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) Arteriosclerotic hypertensive C. V. disease with mitral stenosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH minutes 5 Yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Feb. 22 1956 to April 12 1957 , that I last saw the deceased alive on April 8 1957 , and that death occurred at 11:20 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sharpsburg, Md. DATE SIGNED 4/10/57							
ACTUAL SIGNATURE Walter H. Shealy				PHYSICIAN'S NAME (Type) Walter H. Shealy, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 13 1957		22c. NAME OF CEMETERY OR CREMATORY BROOKSVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) BROOKSVILLE WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE East Funeral Home Boonsboro Md.				24a. REC'D BY REGISTRAR DATE 4 5 1957		24b. REGISTRAR'S SIGNATURE Walter H. Shealy	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

1957

RECEIVED

4547

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS / 144 GREENBERRY RD.	
3. NAME OF DECEASED (Type or print) First RONALD Middle GENE Last MYERS		4. DATE OF DEATH Month APRIL Day 15 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	9. AGE (In years last birthday) yrs 1 9 IF UNDER 1 YEAR: Months 9 Days 9 Hours 9 Min. 9
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GUY W. MYERS		14. MOTHER'S MAIDEN NAME HELEN VA. McCAULEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, go unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. GUY W. MYERS		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL ANOXIA 753.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) HEART FAILURE DUE TO (c) ADRENAL CORTICAL ATROPHY			INTERVAL BETWEEN ONSET AND DEATH 2 HRS 2 HRS 6 WKS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPER TROPHIC PYLORIC STENOSIS			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from APR. 5, 1957 , to APR. 15, 1957 , that I last saw the deceased alive on APR. 15, 1957 , and that death occurred at 8 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 131 W. Washington St. Hagerstown Md. DATE SIGNED 4/16/57			
ACTUAL SIGNATURE Elaine K. Donnellan M.D.		PHYSICIAN'S NAME (Type) DR. FLAINE K. DONNELLAN	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/17/57	22c. NAME OF CEMETERY OR CREMATORY BROADFORDING CHURCH OF BRETHREN	22d. LOCATION (City, town, or county) (State) WASHINGTON CO. MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norman, Hagerstown, Md.		24a. REC'D BY REGISTRAR Apr. 18, 1957 24b. REGISTRAR'S SIGNATURE Frank H. Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 22 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04563

Reg. Dist. No.

4582

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROHRERSVILLE		c. LENGTH OF STAY IN 1b 45 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROHRERSVILLE		e. IS RES. DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SCHOOL ROAD				d. STREET ADDRESS SCHOOL ROAD			
3. NAME OF DECEASED (Type or print) First JESSE Middle V. Last NICHOLS				4. DATE OF DEATH Month APRIL Day 28 Year 1957 19			
5. SEX male	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 7 1872	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED EMPLOYEE OF B.&O.R.R.CO.			10b. KIND OF BUSINESS OR INDUSTRY SAMPLES MANOR WASH.CO.MD.U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME EMANUEL NICHOLS			14. MOTHER'S MAIDEN NAME MAHALA BROWN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MISS ROSE E. NICHOLS ROHRERSVILLE MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic myocardial heart disease DUE TO myocardial heart failure grade IV Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (d) (e) cause lost. (f) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. ---		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. None p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) ---	(County) ---	(State) ---		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 1 1957	22c. NAME OF CEMETERY OR CREMATORY ROHRERSVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) ROHRERSVILLE WASH.CO.MD.		
23. FUNERAL DIRECTOR'S SIGNATURE East Funeral Home Baltimore Md.				24a. REC'D BY REGISTRAR DATE 4/29/57		24b. REGISTRAR'S SIGNATURE S. Robert Wells	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY 2 1907

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04564

Reg. Dist. No. 302

4548

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>												
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 Hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>												
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>6 South Vermont Street</u>												
3. NAME OF DECEASED (Type or print) First <u>Ray</u> Middle <u>Reardon</u> Last <u>Obitts</u>				4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>19 57</u>												
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>												
8. DATE OF BIRTH <u>Dec. 8, 1920</u>		9. AGE (In years last birthday) <u>36</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS</td> </tr> <tr> <td>Months <u>4</u> Days <u>14</u></td> <td>Hours <u> </u> Min. <u> </u></td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS	Months <u>4</u> Days <u>14</u>	Hours <u> </u> Min. <u> </u>									
IF UNDER 1 YEAR	IF UNDER 24 HRS															
Months <u>4</u> Days <u>14</u>	Hours <u> </u> Min. <u> </u>															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Odd Jobs</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport, Md.</u>												
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John William Obitts</u>												
14. MOTHER'S MAIDEN NAME <u>Prudence Young</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>												
16. SOCIAL SECURITY NO. <u>World War II 213-18-9642</u>		17. INFORMANT <u>Mrs. Naomi McCardell Williamsport, Md.</u>														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Employment - Construction</u> </td> <td rowspan="3" style="vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH <u> </u> </td> </tr> <tr> <td colspan="2"> DUE TO <u> </u> </td> </tr> <tr> <td colspan="2"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u> </td> </tr> <tr> <td colspan="3"> DUE TO (c) <u> </u> </td> <td rowspan="2"></td> </tr> </table>						PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Employment - Construction</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	DUE TO <u> </u>		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>		DUE TO (c) <u> </u>			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Employment - Construction</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>														
DUE TO <u> </u>																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>																
DUE TO (c) <u> </u>																
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u> </u> Hour <u> </u> a. m. <u> </u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)												
20f. (City or town)		(County)		(State)												
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .																
ACTUAL SIGNATURE <u> </u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u> </u>												
EXAMINER'S NAME (Type) <u> </u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>												
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 25, '57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>												
22d. LOCATION (City, town, or county) <u>Williamsport, Maryland</u>		(State)														
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u>		ADDRESS <u> </u>		24a. REC'D BY REGISTRAR <u> </u>												
24b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u>Apr. 24, 1957</u>														

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04565

4549

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 7 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 117 North Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Edward Last Plummer				4. DATE OF DEATH Month April Day 22 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1889	9. AGE (In years last birthday) 67 yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) action builder				10b. KIND OF BUSINESS OR INDUSTRY organ		11. BIRTHPLACE (State or foreign country) Bridgeport Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Frederick H. Plummer				14. MOTHER'S MAIDEN NAME Fannie V. Craley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-09-083		17. INFORMANT Mrs. Jeannette Plummer Address Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) Arteriosclerotic heart disease						INTERVAL BETWEEN ONSET AND DEATH 7 days 9 yr. Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 9 p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from October, 1948 , to April 22, 1957 , that I last saw the deceased alive on April 21, 1957 , and that death occurred at 12 Noon , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 148 West Washington St., Hagerstown Md. DATE SIGNED 4/23/57							
ACTUAL SIGNATURE B. B. Kniesley				M.D. 148 West Washington St., Hagerstown Md.			
PHYSICIAN'S NAME (Type) B. B. Kniesley				148 W. Washington St. Hagerstown Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR APR 25 1957	
				24b. REGISTRAR'S SIGNATURE W. H. Bowers			

BUREAU V. 1.

2501 4-1-55.

RECEIVED

4550

CERTIFICATE OF DEATH

MEDICAL CERTIFICATION

VS A15 (4)
ISM 9/55

RECEIVED

APR 11 1957

BUREAU V. S.

4551

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>1 yr 8 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Charles</u>		First Middle Last <u>Remaley</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>30</u> Year <u>1957</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct 5, 1870</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JANITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PAPER PRODUCTS COMPANY</u>		11 BIRTHPLACE (State or foreign country) <u>JACOBSBURG, PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John REMALEK</u>				14. MOTHER'S MAIDEN NAME <u>LUCY QUEENS</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO <u>174-10-6580A</u>		17 INFORMANT <u>MRS. CHARLES SIDERGRIN</u> Address <u>HAGERSTOWN, MD.</u>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease with congestive failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb.</u> 19 <u>53</u> to <u>April 30</u> 19 <u>57</u> , that I last saw the deceased alive on <u>April 29</u> 19 <u>57</u> , and that death occurred at <u>4:35 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>148 West Washington St. Hagerstown, Md.</u> DATE SIGNED <u>4/30/57</u>							
ACTUAL SIGNATURE <u>B. B. Kneisley</u>				M.D. <u>148 West Washington St. Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/3/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNT CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BATH PENNSYLVANIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Rouzer</u> ADDRESS <u>HAGERSTOWN, MD.</u>				24a. REC'D BY REGISTRAR <u>May 7, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas H. Kewers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04567

4552

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 119 King St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last James Henry Rowan				4. DATE OF DEATH Month Day Year April 27 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1900		9. AGE (In years last birthday) 56 yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) service man		10b. KIND OF BUSINESS OR INDUSTRY calculating Mach.		11. BIRTHPLACE (State or foreign country) Pittsburg, Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James C. Rowan				14. MOTHER'S MAIDEN NAME Catherine Morris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO (If yes, give year or dates of service) W. W. II 174-03-274		17. INFORMANT Address Mrs. Emma Hetzler, Pittsburg, Penna.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric ulcer - Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Partial Gastrectomy DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 4 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 7, 1957 , to April 27, 1957 , that I last saw the deceased alive on April 26, 1957 , and that death occurred at 4:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 159 W. Washington St., Hagerstown, Md. DATE SIGNED 4/29/57							
ACTUAL SIGNATURE <i>Philip J. Hirshman</i>		PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 4-30-57		22c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				24a. REC'D BY REGISTRAR May 1, 1957		24b. REGISTRAR'S SIGNATURE <i>Frank H. Bowers</i>	

RECEIVED

MAY 3 1957

BUREAU V. S.

4553

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>25 High Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK JACKSON RUSSELL</u>				4. DATE OF DEATH Month Day Year <u>April 11 1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 1, 1892</u>		9. AGE (in years last birthday) <u>64</u> yrs	IF UNDER 1 YEAR Months Days Hours Min. <u>6 10</u>	IF UNDER 24 HRS <u>1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engine Hostler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Russell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Albert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W.I. 705-10-8590</u>		17. INFORMANT Address <u>Mrs. Agnes S. Russell Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u> <u>4.2.2.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 15</u> , 1957, to <u>Apr 11</u> , 1957, that I last saw the deceased alive on <u>4-11</u> , 1957, and that death occurred at <u>4:45</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert P. Conrad</u>				ADDRESS (Street, city or town, state) <u>137 W Washington Hagerstown, Md</u>		DATE SIGNED <u>4-12-57</u>	
PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/14/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Anger</u>				ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>Apr. 15, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>John H. Howard</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAR 17 1957
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 305

4583

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonesboro				c. LENGTH OF STAY IN b 6 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fahrney-Keedy Memorial Home				e. STREET ADDRESS 1910 Virginia Ave.			
3. NAME OF DECEASED (Type or print) Lula May Santman				4. DATE OF DEATH Month April Day 1 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1976	9. AGE (In years (birthday) yrs) 80	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Germantown Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William L. G. Appleby				14. MOTHER'S MAIDEN NAME Augusta Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address W. J. Santman Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Inter-arteriosclerosis - emboli Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fractured Hip - DUE TO (c) 2 wks. 6 wks.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 703.7						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell while standing in middle of floor					
20c. TIME OF INJURY Month, Day, Year Hour a. m. March 4 1957 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) F.K. Home for Aged Boonsboro		20f. (City or town) Washington Md	(County) (State)	
21. I certify that I attended the deceased from Feb 2 , 1957, to April 1 , 1957, that I last saw the deceased alive on March 31 , 1957, and that death occurred at 3:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE G. W. LeVan		M.D. Boonsboro		ADDRESS (Street, city or town, state) Boonsboro, Md.		DATE SIGNED 4/2/57	
PHYSICIAN'S NAME (Type) Gerald W. LeVan, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DATE April 6 1957	
				24b. REGISTRAR'S SIGNATURE James H. W. B.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar p. burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04570

4551

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washin ton</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>8 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>217 West Washington Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ROY</u> Middle <u>PORTER</u> Last <u>SHREINER</u>				4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 17, 1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Supervisor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Western Union Tele.</u>			
11. BIRTHPLACE (State or foreign country) <u>Chambersburg, Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Sam Shreiner</u>				14. MOTHER'S MAIDEN NAME <u>Mary Porter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-09-7955</u>		17. INFORMANT <u>Mrs. Sarah E. Shreiner Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Heart Disease</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>12 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-1-1956</u> , to <u>4-27-1957</u> , that I lost s/he the deceased alive on <u>4-26-1957</u> , and that death occurred at <u>4:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>D. EW. Smith</u>				ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>D. EW. Smith</u>				DATE SIGNED <u>4/27/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/30/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Apr. 29, 1957</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>	

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MAY 1 1957

BUREAU V. S.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 FilmG2114 4-23-57 et
4555
CERTIFICATE OF DEATH

04571

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Wash. Co. Hagerstown MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Smith Last Smith				4. DATE OF DEATH Month April Day 12 Year 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/12/57	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Shirley Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT Shirley Smith 334 N. Jonathan St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 17 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from April 12, 1957 , to April 12, 1957 , that I last saw the deceased alive on April 12, 1957 , and that death occurred at 7 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE Philip J. Hirshman				M.D. Hagerstown, Maryland 4/15/57			
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Watson Jr. Hagerstown Md.				24a. REC'D BY REGISTRAR Apr. 16, 1957		24b. REGISTRAR'S SIGNATURE Charles H. Gowers	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4556

CERTIFICATE OF DEATH

Reg. Dist. No. 04532

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 619 GEORGE ST.			
3. NAME OF DECEASED (Type or print) DEBORAH KAY SMITH				4. DATE OF DEATH Month APRIL Day 22 Year 19 57			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/20/57		9. AGE (In years last birthday) yrs 2		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		12. CITIZENSHIP OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CARL E. SMITH				14. MOTHER'S MAIDEN NAME HELEN A. BIDDLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. HELEN A. SMITH		HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776 X Immediacy DUE TO Parturition - 6 Mos. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Parturition - 6 Mos. (c) unknown.						INTERVAL BETWEEN ONSET AND DEATH 6 mo 6 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-20 , 19 57 , to 4-22 , 19 57 , that I last saw the deceased alive on April 21 , 19 57 , and that death occurred at 7 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 119 S. Washington DATE SIGNED 9/2/57							
ACTUAL SIGNATURE Miss S. M. Smith M.D.				PHYSICIAN'S NAME (Type) LEWIS S. GRAFF			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/23/57		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Apr. 25, 1957	
				24b. REGISTRAR'S SIGNATURE Phyllis Bowers			

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04573

4584

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg		c. LENGTH OF STAY IN lb Bolling Air Force Base	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Richard Middle Eugene Last Smith		4. DATE OF DEATH Month April Day 20 Year 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 17, 1934
9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY U. S. Air Force	
11. BIRTHPLACE (State or foreign country) Smithsburg, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Benjamin E. Smith		14. MOTHER'S MAIDEN NAME Florence Irene Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 9-11-52 to 214-30-1898	
17. INFORMANT Mrs. Florence I. Needy, Smithsburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 23X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20	
20c. TIME OF INJURY Month, Day, Year 4-21-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1164		20f. (City or town) (County) (State) Smithsburg, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Edw. Ditto, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edw. Ditto, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-23-57	
22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		24a. REC'D BY REGISTRAR APR 25 '57	
		24b. REGISTRAR'S SIGNATURE Alfred	

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

BUREAU V. S.

173 15 1957

RECEIVED

4585

CERTIFICATE OF DEATH

Reg. Dist. No. 005

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LOCUST GROVE				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROHRERSVILLE M.R.I.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL JACOB SMITH				4. DATE OF DEATH Month Day Year APRIL 11 1957 19			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 28 1883 74		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED EMPLOYEE				10b. KIND OF BUSINESS OR INDUSTRY FAIRCHILD AIRCRAFT LOCUST GROVE WASH.		11. BIRTHPLACE (State or foreign country) CO. MD. U.S.A.	
13. FATHER'S NAME SAMUEL SMITH				14. MOTHER'S MAIDEN NAME ANNA GROSS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220 09 9131		17. INFORMANT Address MRS. MYRTLE SMITH ROHRERSVILLE MD. R.I.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate 197X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X						INTERVAL BETWEEN ONSET AND DEATH 3 yrs 18 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 18, 1957 , to April 11, 1957 , that I last saw the deceased alive on April 10, 1957 , and that death occurred at 2 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature] M.D.				ADDRESS (Street, city or town, state) Boonsboro DATE SIGNED 4/13/57			
PHYSICIAN'S NAME (Type) G. W. Hevan				22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			
22b. DATE THEREOF APRIL 14 1957		22c. NAME OF CEMETERY OR CREMATORY LOCUST GROVE CEMETERY		22d. LOCATION (City, town, or county) (State) LOCUST GROVE WASH. CO. MD.			
23. FUNERAL DIRECTOR'S SIGNATURE Boat Funeral Home				ADDRESS Boonsboro Md.		24a. REC'D BY REGISTRAR DATE Apr 5 1957	
24b. REGISTRAR'S SIGNATURE [Signature]							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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APR 17 1957

BUREAU V. S.

4557

CERTIFICATE OF DEATH

04575

Dr. Ditto Jr.

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 22 Years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1113 Salem Ave		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1113 Salem Ave e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) R. E. Spessard		4. DATE OF DEATH Month April Day 25 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1907
9. AGE (In years last birthday) 49 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sand Blast Operator Pangborn		10b. KIND OF BUSINESS OR INDUSTRY Hagerstown, Md	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Cleggett Spessard		14. MOTHER'S MAIDEN NAME Annie Whitmore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 219-12-0399	
17. INFORMANT Mrs Mildred Spessard		Address 1113 Salem Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 180X DUE TO Carcinoma Kidney Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 17 mo DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5-1-56 to 4-25-57 , that I last saw the deceased alive on 4-25-57 , and that death occurred at 6:55 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. R. W. Ditto		ADDRESS (Street, city or town, state) Hagerstown Md DATE SIGNED 4/25/57	
PHYSICIAN'S NAME (Type) Dr. R. W. Ditto		Hagerstown Md 4/25/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 27/57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR Apr 30, 1957		24b. REGISTRAR'S SIGNATURE Blanch Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7,8,14:G214 4-30-57

4558

CERTIFICATE OF DEATH

Reg. Dist. No.

04575
302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Memorial Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City			
f. STREET ADDRESS 3331 Virginia Ave.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edith Middle Kirl Last Sylvester				4. DATE OF DEATH Month April Day 1 Year 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 7, 1876	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min 10		11. IF UNDER 24 HRS Months 10 Days 10 Hours 10 Min 10		12. IF UNDER 24 HRS Months 10 Days 10 Hours 10 Min 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Baltimore City, Md.	
12. CITIZEN OF WHAT COUNTRY? house wife				13. FATHER'S NAME Edward Perkins			
14. MOTHER'S MAIDEN NAME Alice E. Meekin				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO ---				17. INFORMANT Elmer Sylvester, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO General Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 yrs. (c) 10 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11 Month 19 Day 19 Year 1957 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1956 to April 1, 1957 , and that I last saw the deceased alive on April 1, 1957 , and that death occurred at 10:10 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Jack H. Beachley				M.D. 221 W. Washington St., Hagerstown			
PHYSICIAN'S NAME (Type) Jack H. Beachley, M.D.				ADDRESS 221 W. Washington St., Hagerstown			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-4-57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				24a. REC'D BY REGISTRAR 4.1957			
24b. REGISTRAR'S SIGNATURE Chas. Bowers							

BUREAU V. S.

APR 2 1917

RECEIVED

4559
CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4 East Antietam St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE LAST BERTIE MAY TAYLOR		4. DATE OF DEATH Month Day Year April 25 19 57					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1883	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Millstone, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alex Myers				14. MOTHER'S MAIDEN NAME Della Myers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-32-5278		17. INFORMANT Address Mr. J. W. Taylor 4 E. Antietam St. Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis of the Cerebral Arteries DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intracerebral hemorrhage - type undetermined							INTERVAL BETWEEN ONSET AND DEATH 3 mos. 1 wk.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 23, 1949, to April 25, 1957, that I last saw the deceased alive on April 25, 1957, and that death occurred at 12:30 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE L. L. Packer J.				ADDRESS (Street, city or town, state) 145 W. Wash St. Hagerstown Md.			
PHYSICIAN'S NAME (Type) L. L. Packer M.D.				DATE SIGNED 145 W. Washington St. Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27/57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Clearspring Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.				24a. REC'D BY REGISTRAR Apr. 27, 1957		24b. REGISTRAR'S SIGNATURE [Signature]	

Wm. C. Host. U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED


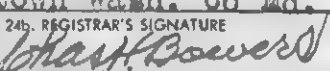
APR 30 1957

BUREAU V. S.

4560

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 9 weeks		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kartlin Manor Nursing Home						d. STREET ADDRESS 249 So Locust St			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First ELIZA		Middle JANE		Last TOWSON		4. DATE OF DEATH Month April		Day 28	
5 SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feby 9 1877		9. AGE (In years last birthday) 80 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Thomas Foster						14. MOTHER'S MAIDEN NAME No Record					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Anna E. Everly 249 So Locust St							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epidermoid Carcinoma of Bladder 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease 14 months										INTERVAL BETWEEN ONSET AND DEATH 7 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown Md.		(County) (State)	
21. I certify that I attended the deceased from Jan 1957 , to 4-28-57 , 19 57 that I last saw the deceased alive on 4-27-57 , and that death occurred at 4:00A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED											
ACTUAL SIGNATURE 				M.D. 100 Professional Arts Bldg. 4-28-57							
PHYSICIAN'S NAME (Type) William T. Layman, M.D.				Hagerstown Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/30/57		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.						24a. REC'D BY REGISTRAR 4/30/57		24b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 2 1911

RECEIVED

4561 CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. STREET ADDRESS <u>225 Mill Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Virginia</u> Last <u>Turner</u>		4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 2, 1910</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Martinsburg, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Myers</u>		14. MOTHER'S MAIDEN NAME <u>Bessie V. Koontz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Raymont S. Turner</u>		Address <u>225 Mill Street</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Biliary Cirrhosis</u> DUE TO (b) <u>Biliary Duct Stricture</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary anemia</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 4, 1955</u> to <u>April 2, 1957</u> , that I last saw the deceased alive on <u>April 1, 1957</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Harrison</u>		ADDRESS (Street, city or town, state) <u>318 No Potomac St Hagerstown Md</u>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Dr Paul Harrison</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 4/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>Apr 3, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frank Bowser</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 5 1957

BUREAU V. I.

4562

CERTIFICATE OF DEATH

04580

Reg. Dist. No. 302

1 PLACE OF DEATH a COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE Maryland b COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital give street address) Washington County Hospital		e. STREET ADDRESS 31 Fenton Ave.	
3. NAME OF DECEASED (Type or print) First Richard Middle Preston Last Turner		4. DATE OF DEATH Month April Day 10 Year 1957	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 6 1878
9. AGE (in years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 1 Days 3 Hours Min 	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10b KIND OF BUSINESS OR INDUSTRY Byrons Tannery	
11 BIRTHPLACE (State or foreign country) Cumberland Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A	
13 FATHER'S NAME John Turner		14 MOTHER'S MAIDEN NAME Anna Mary Popp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO 215-01-9881	
17. INFORMANT Mrs. Pearl Turner		Address 31 Fenton Ave. Williamsport Md.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic nephrosclerosis DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 2 weeks unknown
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarction 4 days duration			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 4, 19 57, to April 10, 19 57, that I last saw the deceased alive on April 10, 19 57, and that death occurred at 7:05 pm from the causes and on the date stated above.			
ACTUAL SIGNATURE Archie Robert Cohen		DATE SIGNED 4/12/57	
PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.		ADDRESS (Street, city or town, state) Clear Spring, Maryland	
22a BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 13-57	22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	22d. LOCATION (City, town, or county) (State) Williamsport Maryland
23 FUNERAL DIRECTOR'S SIGNATURE Edwin V. Leaf		24a REC'D BY REGISTRAR Blas H. Powers	
24b REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1957

BUREAU W. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4563 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

04582

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 Hour</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL—Pinesburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Washington County Hospital</u>				d. STREET ADDRESS <u>Williamsport, R.F.D. #2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>Edwin</u> Last <u>Wetzel</u>				4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1957</u>			
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 11, 1922</u>		9. AGE (In years last birthday) <u>34</u> yrs.	IF UNDER 1 YEAR <u>34</u> Mo. <u>6</u> Ds. <u>13</u> Min.	IF UNDER 24 HRS. <u>13</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild Aircraft</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harvey William Wetzel</u>				14. MOTHER'S MAIDEN NAME <u>Audrey Acord</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>Yes</u> <u>World War II</u>		16. SOCIAL SECURITY NO. <u>718-01-4335</u>		17. INFORMANT <u>Mrs. Mabel Wetzel Williamsport, Md. RFD #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>4/20/57</u> DUE TO <u>Arteriosclerotic coronary heart disease</u> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ <u>none</u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	20f. (City or town) _____	(County) _____	(State) _____	
27. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Williamsport, Md.</u>		24a. REC'D BY REGISTRAR <u>Apr. 29, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

RECEIVED

MAY 1 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4564

CERTIFICATE OF DEATH

04581

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 4 Downsville Pike			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last James Frank Wiebel, Sr.				4. DATE OF DEATH Month Day Year April 14, 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1, 1893	
9. AGE (In years last birthday) yrs. 64		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours M. n.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) rural carrier				10b. KIND OF BUSINESS OR INDUSTRY post office Dep.			
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Augusta Wiebel				14. MOTHER'S MAIDEN NAME Henrietta Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW I - -		17. INFORMANT Address Mrs. Helen Wiebel, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction - acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac decompensation DUE TO (c) General arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb. 18, 1957 , to Apr. 14, 1957 , that I last saw the deceased alive on Apr. 14, 1957 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward W. Ditto, III M.D.				ADDRESS (Street, city or town, state) 217 W. Washington St.			
DATE SIGNED 4/15/57							
PHYSICIAN'S NAME (Type) Edward W. Ditto, III, M.D.				217 W. Washington St., Hagerstown			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-16-57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				ADDRESS Apr 18 1957		24a. REC'D BY REGISTRAR Edward W. Ditto, III	
				24b. REGISTRAR'S SIGNATURE			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for a burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04583

4565

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. CO- Hosp</u>				d. STREET ADDRESS <u>1938 Pope Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cheryl</u> Middle <u>Lynn</u> Last <u>Wingerd</u>				4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16, 1957</u>	9. AGE (In years last birthday) yrs. <u>45</u>	IF UNDER 1 YEAR Months <u>45</u> Days <u>45</u> Hours <u>45</u> Min. <u>45</u>		IF UNDER 24 HRS. <u>45</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>Wash-co-Hosp</u>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>George Martin Wingerd</u>			
14. MOTHER'S MAIDEN NAME <u>Vivian Amelia Spence</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mother</u> Address <u>938 Pope Ave Hagg. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>758.6</u> DUE TO <u>Congenital defect</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Abnorm of spine column & cranium</u> DUE TO (c) <u>Abnorm of spine column & cranium</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>46 Month</u> INTERVAL BETWEEN ONSET AND DEATH <u>46 Month</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4-16-1957</u> to <u>4-16-1957</u> , that I last saw the deceased alive on <u>4-16-1957</u> , and that death occurred at <u>4:14</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown Md.</u> DATE SIGNED <u>Dr. E. J. Otto Jr.</u> ACTUAL SIGNATURE <u>A. E. W. White Jr.</u> M.D. <u>Dr. E. J. Otto Jr.</u> PHYSICIAN'S NAME (Type) <u>A. E. W. White Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>April 19, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>HAGERSTOWN</u>				22e. (State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Williams</u>				ADDRESS <u>Williamsport, Md.</u>		24a. REC'D BY REGISTRAR <u>Apr 19, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>				24c. (City, town, or county) <u>Hagerstown Md.</u>			

2181316 XVI

CERTIFICATE OF DEATH

WESTLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

BUREAU V. A.

APR 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4566

CERTIFICATE OF DEATH

04584

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle 75x3</u>	
c. LENGTH OF STAY IN 1b <u>2 WKS</u>		d. STREET ADDRESS <u>123 South Carlisle St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Phyllis Regina Wingerd</u>		4. DATE OF DEATH <u>April 7, 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5, 1929</u>
9. AGE (In years last birthday) <u>27</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House keeping</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland Co. Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Coyl E. Barrick</u>		14. MOTHER'S MAIDEN NAME <u>Erna Swartz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unable to obtain</u>	
17. INFORMANT <u>Mr. Richard C. Wingerd, Greencastle Pa</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic glomerulonephritis</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 mos</u> <u>years.</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pericarditis, Pneumonia, Pulm. edema.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6 April, 1957</u> to <u>7 April, 1957</u> , that I last saw the deceased alive on <u>7 April, 1957</u> , and that death occurred at <u>7:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard T. Binford</u> M.D.		ADDRESS (Street, city or town, state) <u>HAGERSTOWN, MARYLAND</u>	
DATE SIGNED <u>9 APRIL 1957</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD T. BINFORD, M.D.</u>		<u>1135 POTOMAC AVENUE HAGERSTOWN, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/10/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Greencastle Franklin Co. Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold W. Zimmerman</u>		ADDRESS <u>Greencastle, Pa</u>	
24a. REC'D BY REGISTRAR <u>Apr. 11, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Bowers</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - DIVISION 12
CERTIFICATE OF DEATH

BUREAU V. 2

APR 15 1957

1135 POTOMAC AVENUE HAGERSTOWN, MARYLAND

RICHARD T. BINFORD, M.D.

Richard T. Binford

RECEIVED